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AGENDA COVER MEMO

AGENDA DATE: May 6, 2003

TO: Board of County Commissioners

FROM: Rob Rockstroh, Director
Department of Health & Human Services

AGENDA TITLE: SEMI-ANNUAL BOARD OF HEALTH REPORT

The following report to the Board of Health is a summary of recent or current health and human service highlights or possible future directions. It is designed to keep the Board advised of the status of health and human services in Lane County.

The report deals with each program area separately, although as a health and human service system, services are integrated to the greatest degree possible to ensure our support of Lane County citizens' health in an effective and efficient manner.

I. SPECIAL SERVICES / ADMINISTRATION

Family Mediation Program (Barbara Lee, Program Manager)

For the six-month period September 1, 2002 through February 28, 2003, the Family Mediation Program completed a total of 212 court-referred domestic relations cases involving child custody and parenting time legal actions. In addition to providing mediation in court-referred cases, the program provides information and referral services to Lane County's divorcing, separating, and divorced parents who are not program clients. During the six-month period, a total of 554 parents attended the program's court-connected class "Focus on Children." Attendance at Focus on Children or a similar class is required for divorcing or separating Lane County parents of minor children. The class addresses parental planning and children's needs when families are in transition. "Focus on Children" is a self-supporting class funded by participants' fees. No individual is turned away due to inability to pay.

Prevention Program (Karen Gaffney, Assistant Department Director)

The purpose of the prevention program is to promote and coordinate effective community-based prevention strategies toward creating healthier communities. Activities supported through the prevention program can be categorized within the six Center for Substance Abuse Prevention (CSAP) strategies for effective prevention efforts: information dissemination, prevention education, environmental strategies, alternative activities, community-based processes, and identification and referral.

On Sunday February 2, 2003, from 6-7p.m., the four local television stations that make-up Media United Against Drugs simultaneously aired the fourth annual hour-long, commercial-free television town hall on substance abuse prevention. The show was called "Strategies

for a Drug Free Future" and was co-hosted by news anchors from KMTR, KVAL, KEZI and FOX-KEVU. It featured local Lane County experts along with local vignettes that provided the viewing audience with information on the dangers of youth use of alcohol, tobacco, marijuana and inhalants and how positive, proactive parenting can be a strong deterrent to youth use of these drugs. Local media teamed-up with two members of the H&HS prevention team to organize and air the show. Some of the results from the airing of the show were:

- Media United received 58 telephone calls; 35 of those calls were for local information and referral.
- There were 529 hits to the mediaunited.org website.
- 72 hits were to the home page and 27 hits were to receive information and referral.

The program is also working with the Lane County Prevention Coalition (LCPC) to organize community efforts to reduce underage drinking. Supported through a small state grant, Lane County contracted with FACE, a national non-profit organization that conducts work in the area of media development on key alcohol issues. FACE converted and customized a poster to be specific to Lane County. These five posters (one in Spanish, four in English) were placed on Lane Transit Authority busses from January – February 2003. The Coalition also collaborated with Lane Education Service District and Eugene area radio stations to rebroadcast six parenting radio spots written by members of the Coalition. These spots were aired during January and February 2003 on 20 stations at least 15 times during two months, or about 450 times. Lane County staff received about ten phone calls from this campaign including some generated from a January 10, 2003 Register-Guard article about the campaign.

Another component targeting underage drinking is compliance checks of alcohol vendors in rural areas. In January and February, the Coalition partnered with the Oregon Liquor Control Commission and Youth In Action to conduct 58 first time compliance checks. Forty-two retailers who appropriately "carded" youth received a recognition award from the coalition and Youth In Action. The vendors who failed the compliance checks (16) had an opportunity to receive a $309 credit from the LCPC toward purchasing age verification equipment that works to deter vendors from selling alcohol to people who either have false ID or who are underage using their own ID. These 16 retailers will be re-checked later during the year to assess whether the age verification machines are effective in deterring sales to minors. The Coalition selected this strategy of "reward and reminder" because (1) research shows that restricted availability is a deterrent to use and (2) we want to show our retailers that by partnering together, we can reduce underage drinking.

The prevention program continues to work with the Heroin Task Force (HTF), a multidisciplinary, community-based group, to develop and implement strategies to impact the heroin problem in Lane County. The group meets monthly to share new information about the changing local heroin problem, and to network about available resources. The HTF recognizes that hospitals are often the first point of contact for people who have injuries and illnesses that are related to or caused by substance use and abuse. The two regional hospitals in Lane County's metro area do not have written standards on how to screen, assess, treat, medicate and/or refer youth and adult patients who are drug affected/addicted. Since December 2002, the HTF has begun to research effective

substance abuse protocols for hospital adoption. This will provide all medical personnel with policy guidelines to uniformly assist patients. Working toward creating universal standards of medical care will do much to assure uniform screening, assessment, treatment and referral.

Another significant part of Lane County's prevention efforts is the Gambling Awareness & Prevention Program (GAPP). Formed in January 2002, the program's goals are: 1) to heighten community awareness about the dangers of problem and pathological gambling; 2) to provide information about local problem gambling resources and services; and 3) to reduce the negative effects of gambling by implementing a gambling prevention strategy targeting youth and families. Over the last year, GAPP has worked to achieve these goals through several projects, including development and provision of workshops to middle school, high school, and at-risk youth, presentations to community groups and agencies, outreach to the Latino and rural communities of Lane County, formation of a problem gambling issues committee, and participation in the first-ever Oregon Problem Gambling Awareness Week efforts.

Since its inception, GAPP has directly reached almost 1,000 youth (ages 12-19) through school-based presentations, health workshops, and at-risk youth program presentations. Evaluations from youth exposed to school-based presentations have produced interesting results; self-report from these youth indicates the average onset of gambling behavior is eight years old. The evaluations have also shown marked increases in awareness among middle and high school students exposed to GAPP youth presentations.

Most recently, GAPP actively participated in local and statewide efforts for the first-ever Oregon Problem Gambling Awareness Week (March 10-16, 2003). These efforts included helping to shape a statewide community resource manual for gambling prevention and treatment providers, planning of a local rally to celebrate gambling awareness and hope, green-and-white ribbon week to heighten awareness of problem gambling in Lane County, a poster search (contest) for middle-school youth, ads on four LTD busses for the Spanish-speaking community, and public service announcements in English and Spanish on 20 Eugene area radio stations.

In addition to direct prevention and projects, the prevention program also provides system support through planning and coordination. Prevention staff recently completed and submitted the 2003-2005 biennial Alcohol and Drug Prevention Plan. Through a process of engaging community members and other publicly funded partners, and support for the coordinated plan developed as a result of SB555, the plan reflects a collaborative effort that will target children of alcoholics/addicts, families and support for community-based prevention efforts. Systems coordination continues to receive significant time. Staff continues to coordinate the monthly "coordinators committee" which has proven to be a helpful vehicle for greater cooperation among efforts. Countywide prevention efforts, including Success by Six, Family Violence Response Initiative and the rural Safe Schools Healthy Students initiatives, are some of the areas represented at this meeting. Also, shared planning and coordination of targeted events, such as the regional Oregon PeaceMakers Conference for middle and high school youth, has become integral to the regular workload of prevention staff. Last year's PeaceMakers Conference included approximately 300 youth from this region and culminated in presentation by youth of the

"peace pole" which is now placed in the Public Service Building.

II. DEVELOPMENTAL DISABILITIES SERVICES (Lynn Greenwood, Program Manager)

Lane County Developmental Disabilities Services (DDS) provides an array of community-based services and supports for individuals with developmental disabilities and their families. The program's professional staff directly provides lifespan case management for 1,354 Lane County residents who meet eligibility criteria. In addition, the program subcontracts with sixteen local agencies, 70 adult foster providers and ten children's foster providers for services that include residential placement and supported living, employment, alternatives to employment, crisis resolution and family support services. The program also serves as the lead agency in Lane County for providing protective services for adults with developmental disabilities. This includes investigating reports of neglect and abuse within the county's system of subcontracted comprehensive services.

Universal Access: The universal access initiative created by the Staley lawsuit settlement with the state of Oregon has been slowed down considerably during the past several months due to budget issues at the state Department of Human Services. To date, 170 Lane County consumers have transferred to the Full Access Brokerage in Eugene where they now receive services that had previously been administered by the county through case management and family support revenues. The County's role in this new system of services is to provide Title XIX (Medicaid) administration for the plans consumers develop with staff at the brokerage. The slowdown of the Staley "rollout" for the rest of the current fiscal year and going into the next biennium adds to the already overwhelming workload of staff at the County since caseload sizes were projected on full implementation of the brokerage. As additional budget information becomes available, DDS will begin another round of planning related to maintaining essential functions and prioritizing other duties as time and resources allow.

Quality Assurance: A Quality Assurance Coordinator was hired in November 2002 with revenue made available to Lane County from the state office of Seniors and Persons with Disabilities. The coordinator had been a mental health specialist with Lane County Mental Health and has an extensive background in mental health, developmental disabilities and occupational therapy. She has been working with our protective services team and our serious event review team and chairs our quality assurance team. She has been able to attend many of the state licensing visits in our subcontracted group homes and employment programs, and is working with our foster coordinator on developing new foster care licensing and oversight protocols as well. The state will be requiring a quality assurance plan for the DD services in our County sometime in the next biennium.

Budget Issues: To date, DDS has reduced FTE by 1.45 and has left a 1.0 FTE position unfilled. We anticipate another 2.55 FTE loss at this point going into the next fiscal year with an additional 1.0 FTE position remaining unfilled. Of course, these are only projections based on current fiscal information available at the state and county level. The impact on services for DD consumers is that as caseloads increase, case management services are prioritized with crisis situations being the main priority. The vulnerability of the population coupled with the severe cuts in mental health and other needed services has already resulted in a diminished ability to respond to people in the DD system with the

same level of quality supports as in the past.

III. HUMAN SERVICES COMMISSION (Steve Manela, Program Manager)

The Human Services Commission's (HSC) conducted a strategic planning process this past year that established the HSC priorities over the FY 2003-2005 biennium. The plan broadly mapped the activities the HSC will pursue to reach its desired goals. It is intended to be a tool to guide decision-making by the HSC on fundamental human service issues and investments. It will contain the mission statement, principles, goals, and strategic objectives. To that end, the strategic plan established the HSC priorities to 1) allocate human and financial resources to accomplish those activities 2) assess whether objectives are being met; and 3) establish means to evaluate programs and resources.

Over 80 community experts and advisors participated in planning groups covering the following key HSC issue areas:

- Emergency / Crisis Services (energy, housing and community services);
- Food and Nutrition (food bank, meal sites, and nutrition programs);
- Health Care and Disability Services (primary health, mental health, alcohol and drug, and disability benefits); and
- Self Sufficiency (supportive housing, case management, independent living, household violence, child care, and other support services).

The planning groups reviewed current activities and activities suggested by community planning documents, and then came up with specific lists of suggested activities and impacts. Planning participants included: commission members, budget planning committee members, provider network representatives, funding representatives, and staff and community experts.

An operational plan is being developed with the guidance of the Human Services Budget Planning Committee and approval of the HSC. The operational plan to be discussed by the HSC on April 15, 2003 will describe the specific actions that must be taken to accomplish each objective identified in the strategic plan.

In developing the operational plan, the HSC is considering the local governmental response to the collapse of major health and human services for vulnerable low-income populations. The HSC budget mirrors the increasing gaps in the larger safety net of governmental and charitable health and human services programs. While needs are increasing, the FY 03-04 budget for the HSC also contains significant reductions in health and human services for vulnerable Lane County residents. At this point, the HSC FY 03-04 budget of $7,697,604 includes removing $504,406 in various one-time and grant-related revenues and expenses. To further balance the budget, we will need to determine reductions of on-going payments to nonprofit providers by $307,000.

Options to balance the budget are severely constrained because the most flexible HSC revenues (Eugene, Springfield and Lane County pooled General Funds and federal block grant funds) are being used substantially to leverage or match other federal, state and

private grants that support basic shelter, food, medical and crisis intervention services. The HSC may be forced to triage services for the poor down to a very basic humanitarian response. Given the steep downsizing of state supported health and human services, the HSC would have to narrow the focus of services to prioritize critical life and health safety responses. One option under consideration is to eliminate discretionary flexible funding of early intervention programs and small grants.

Health Care: Human Services Commission's (HSC) health care strategic planning group reviewed and recommended activities to maintain and increase access to primary and behavioral health care and prescription medicines for the 28,000 low-to-moderate income Lane County households who are uninsured, or lack access to a care provider, or are ineligible for insurance coverage. The following are their recommendations that were included in a report to the HSC.

1. Advocate legislatively on the State and Federal level (City/County United Front and legislative committees) to support the maintenance of eligibility of the Oregon Health Plan (OHP), and other federal and state funded Medicaid and Medicare programs providing access to health care for low and moderate-income Lane County residents.

2. Support the submission of a grant to the federal government for the creation of a Federally Qualified Health Center (FQHC). HSC staff should participate and provide technical assistance with the coalition working to create and write the grant for the FQHC. This effort incorporates assisting the other local safety net clinics and school-based health clinics through creation of an administrative structure for a common billing system for Medicaid and Medicare eligible clients.

3. Work with health centers to increase the number of at-risk children and homeless youth who receive year-round access to strength-based health care, including primary health care, school health physicals, immunizations, family planning, behavioral health services, acute mental health and substance abuse services, and transitional living and on-going care.

4. Improve the availability, access to, and effectiveness of services targeting varied high-risk populations including but not limited to cultural and ethnic minorities, homeless, drug users, mentally-ill, criminal justice system clients, elders, family abuse/trauma victims and perpetrators.

Homeless Prevention Task Force: The HSC and the Housing Policy Board formed a joint task force to propose short-term and long-term solutions to prevent homelessness. An estimated additional 1,800 households may fall into homelessness during 2003. The task force presented their recommendations to the joint policy bodies in January 2003.

Homeless prevention programs assist to stabilize families in their existing homes. Homeless prevention as opposed to providing temporary shelter or offering other short-term solutions to individuals who become homeless, is cost effective, preserves family self-respect and helps to keep families intact. Short-term interventions for the prevention of homelessness serve to prevent the need for long-term assistance programs that are more costly to taxpayers.

More broadly, the HSC funds homeless prevention and assistance programs, assistance that stabilize families in their existing homes, shortens the period of time families stay in emergency shelters, and assists families with securing affordable transitional or permanent housing. The following is a list of some of the major activities sponsored by the HSC:

1. Housing stabilization case management, rent assistance, and supportive housing services — 1,100 households;

2. Eviction prevention by assisting with rental payments - 220 households;

3. Eviction prevention by assisting with utility arrearage payments - 5,000 households;

4. Legal assistance, advice regarding housing and receiving public benefits - 5,280 households (500 evictions; 300 other landlord tenant; 150 habitability; 50 foreclosures);

5. Housing and employment counseling, family budgeting, tenancy education - 400 households;

6. Respite childcare for families in crisis - 800 households;

7. Parent education to promote healthy child development - 200 households; and

8. Counseling to assist with the psychological trauma related to homelessness - 120 households.

Accomplishments: The following are some key accomplishments HSC has achieved during the past quarter:

1. Completed work on the homeless prevention task force to review alternatives to prevent homelessness among low-income people.

2. Partnered with local utility companies to expand low-income energy assistance and conservation services to senior and disabled individuals.

3. Received a $1.3 million grant from the federal Department of Housing and Urban Development to assist homeless persons to become permanently housed.

4. Safe and Sound Program received over $350,000 from foundations to expand behavioral health and alcohol and drug services to homeless youth.

5. Partnered with the City of Eugene to assist non-profit social service agencies with their increased energy bills.

6. TheLane human service information and referral project partnered with United Way Success By Six project to expand parenting and human service information to parents and families in Lane County.

7. Partnered with the Cities of Eugene and Springfield to relocate Food For Lane County's community soup kitchens.

8. Submitted an application to the federal Department of Health and Human Services to develop and operate a Community Health Center.

9. Co-sponsored a Community Health Care Crisis Forum with LIPA.

IV. MENTAL HEALTH SERVICES (Al Levine, Program Manager)

Outpatient Mental Health Clinic

The period since the last Board of Health Report has seen dramatic funding reductions to mental health services, and these have led directly to a number of significant clinic operation changes. First, it was no longer fiscally feasible to maintain separate programs for child and adult mental health services. In order to realize obvious fiscal efficiencies, the child wing of the mental health building was closed in February and the child clinic staff was moved into the previous adult clinic space, with consolidated reception and business support functions. The child clinic staff has been reduced to 2.0 FTE of child clinicians who carry caseloads of over 100 children. Overall, the outpatient clinic staffing was reduced (or will be reduced) from 26 clinicians to 13 by June 30, 2003 due to complete loss of all state funding for indigent care and crisis services as well as loss of the mental health benefit for OHP Standard patients.

We also reduced our medical staff by 1.0 FTE of nursing and 72 hours/week of prescribing time (psychiatry or psychiatric nurse practitioner) and will lose 1.0 FTE Mental Health Supervisor by June 30th. At this point we are down to a bare bones operation, and staff are working very hard to move as many of our clients who no longer have mental health coverage out of care, as we no longer have indigent care funding to serve them. With the loss of the mental health benefit for OHP Standard, the number of essentially "indigent" clients has increased by 300%. In many ways, these unfortunate budget decisions at the state level have eliminated our traditional community mental health mission of "treater of last resort" and community safety net. Our continued financial viability becomes contingent upon our ability to generate revenue from fees for those clients with OHP Plus or Medicare, and we will continue to provide what indigent care we can with some of the County General Fund dollars we receive.

Patients discharged from the Lane County Psychiatric Hospital (LCPH) or under civil commitment will take priority for indigent care slots, with a waiting list established for slots as they become available. Anticipated treatment capacity will be approximately 1,000 adults and 250 children at any point in time, barring any further funding reductions.

Lane County Psychiatric Hospital

Lane County Psychiatric Hospital (LCPH) continues to operate as virtually full on a daily basis, with beds opened from discharges being filled often within the hour. While waiting lists for getting acute care patients approved for extended care into the State Hospital remain large statewide, this problem has been alleviated somewhat locally by the advent of

a creative new cooperative service developed at the Heeran Center. The Post Acute Intensive Treatment Service (PAITS) program was developed to take individuals approved for State Hospital transfer into this "sub-acute" facility and serve them at state expense (through a negotiated daily rate payment paid by OMAP) as an alternative to State Hospital beds. These six beds were made available by the moving of the eight "Passages" long-term clients out of Heeran Center to a new secure residential treatment facility called Garden Place. Lane County residents sitting in local acute facilities get top priority for these PAITS beds, and discussions with the State to expand the number of PAITS beds at Heeran from six-to-ten are underway. Despite this, the waiting list for state beds remain long, and in the last month, 40% of LCPH bed days were taken up by individuals awaiting State Hospital placement.

Demand for inpatient beds remains quite high statewide, and we still have all local acute beds full more often than not, necessitating the need for expensive out-of-area placements and related costly transports. As part of State budget cuts, Lane County was informed that the State will no longer be reimbursing LCPH for patients approved for extended care and awaiting transfer to State Hospital beds. This would become a significant financial burden for LCPH and is an unacceptable shift of State fiscal responsibility. We informed the state that Lane County does not agree with this decision, and we will therefore arrange delivery of such patients to the State Hospital through Delivery Warrants issued by the Circuit Court. OMHAS informed us upon receipt of our letter that they would work with us to expedite such transfers. As of this writing, no such Delivery Warrants have had to be executed. Recent efforts to divert Medicare admissions to the Sacred Heart Johnson Unit are hoped to allow for more LCPH beds being available for LaneCare or indigent clients.

Costs at LCPH continue to rise, largely as a result of increased personnel costs at PeaceHealth and dramatic increases in costs of psychiatric medications. In addition, costs of insurance for the hospital have risen beyond what is reasonable for a facility of this size. We successfully negotiated having LCPH covered under PeaceHealth's self insurance fund at great cost savings to the operation. Recent review of average costs per day show that a day at LCPH currently costs over $760, with an anticipated increase of another $50-$75 per day for next fiscal year. In order to hold some of the cost increases in-check, Lane County has successfully negotiated with PeaceHealth to keep the overall management contract cost relatively flat by realizing some savings through the reduction of some non-critical positions within the hospital. Additional reductions in staffing and perhaps even bed capacity may have to be implemented in this next fiscal year as we submitted a flat-lined budget for LCPH, given all the funding reductions in the system, yet inpatient care costs continue to rise, again primarily in the areas of personnel (nursing) and psychiatric medications. This results then in an effective reduction in service capacity, which can have fallout financially for Lanecare, as fewer beds at LCPH could mean more Lanecare admissions to Sacred Heart's Johnson Unit at higher cost.

At this time, we are in discussion with McKenzie Willamette Hospital and Peace Harbor Hospital in Florence to credential their Emergency Department physicians on LCPH's medical staff. This would allow for some direct admits from those facilities and would reduce the necessity for having additional emergency room visits to accomplish the required medical screening prior to LCPH admission. On a final note, largely due to the state's complete elimination of crisis funding, we gave notice to PeaceHealth that LCMH

would no longer be providing the crisis triage service in their Emergency Department effective February 16, 2003. This decision was made primarily to be sure we had a critical mass of clinicians available to our outpatient clinic.

V. LANECARE (Bruce Abel, Program Manager)

LaneCare is in the middle of its sixth year of operations. LaneCare represents the County's effort at managing a capitated component of the Oregon Health Plan (OHP), the mental health "carve-out", while integrating community mental health responsibilities in partnership with provider agencies. LaneCare contracts with a range of non-profit providers to offer a full continuum of services, to ensure access to services, and to maintain consumer choice. Although LaneCare no longer shares risk with PeaceHealth, LaneCare continues to benefit from our collaboration with PeaceHealth. We plan to continue this relationship through Year 6.

LaneCare has moved into the wonderful new mental health facility. The proximity with Lane County Mental Health has helped operations. PeaceHealth staff that work for LaneCare have co-located with LaneCare in the facility. Due to budget cuts, LaneCare has laid off a total of five different individuals since October 2002.

The State Mental Health Division and OMAP recognize LaneCare as being one of the best-managed and most successful Mental Health Organizations (MHOs) in Oregon. We continue to provide a significantly higher percentage of client encounters than other MHOs. We are effective participants in rate-setting discussions; we chair the State MHO Contractors' meeting and we participate actively in quality improvement activities at the state level. In addition, LaneCare has established effective partnerships with consumers, contracted providers, and other community partners, including the Lane Individual Practice Association (LIPA) and the OHP Fully Capitated Health Plan in Lane County.

Due to state budget deficits there have been several critical changes affecting LaneCare in the past months. This document will try to clarify these changes.

LaneCare receives a capitated amount of funds to pay for mental health treatment for all County residents covered by LaneCare under the OHP. When we started this fiscal year we estimated that the monthly average capitation payment this year would be $1,200,000, for a total annual budget of approximately $15,000,000. Each month there were approximately 35,000-36,000 Lane County residents who are covered by LaneCare and actually received over $1,300,000 per month for October through February.

Due to budget reductions this changed effective March 1, 2003. Approximately 9,000 OHP Standard members lost their enrollment in LaneCare effective March 1, 2003. LaneCare now has a membership of a little over 26,000 members each month. The LaneCare annual budget was reduced by almost $2,000,000 effective March 1st when OHP Standard members lost their mental health benefit. A further reduction of up to 20% of capitation ($2,400,000) is expected in October 2003.

Approximately 20% of LaneCare members access mental health treatment paid for by LaneCare annually, well over 7,000 individuals. We expect this number to decrease by

approximately 1,200 individuals annually due to the membership reduction.

LaneCare was very concerned that the mental health benefit that these 9,000 Lane County citizens are losing will create substantial hardship for certain individuals. Other budget reductions have affected the prescription benefit, alcohol and drug benefit, indigent services, and crisis services for indigent residents. Without critical services and supports, individuals with severe mental illness will have very poor outcomes. LaneCare has stepped up-to-the-plate by committing reserve funds to provide transitional support for individuals and programs. These include co-payment funds, transitional indigent care mental health funds, and crisis system stabilization funds. We do understand that these resources are temporary and that other long-term community fixes will need to be developed.

LaneCare pays for a significant percentage of services provided by Lane County Mental Health. LaneCare also has service contracts with 12 non-profit mental health agencies. A portion of clinical funds is contracted to consumer and parent-run organizations to provide activities to reduce social isolation and for peer supports and other support services. Another portion is dedicated to community-based prevention efforts. LaneCare continues to fund outreach to facility-bound seniors, coordination with developmental disabilities, parent training and suicide prevention for teens, and crisis supports and response. In addition to these programs, LaneCare provides partial funding for outreach to homeless youth and an Internet site (TheLane) that provides community information, including mental health services information. LaneCare publishes two newsletters each month and has published a consumer newsletter quarterly.

In addition, LaneCare contracts with a number of hospitals (Lane County Psychiatric Hospital, Sacred Heart's Johnson Unit), PeaceHealth psychiatry, and has a clinical exception procedure for paying for mental health services for professionals off panel. Flexible funds are committed to support clients in treatment alternatives in ways that could not be billed.

The quality assurance process continues to help review policies, procedures and practice of the LaneCare funded mental health service system. As part of LaneCare's on-going quality improvement efforts, we have:

- Continued to provide trainings for our panel of participating practitioners;
- Completed site visits for all sub-contracted provider agencies;
- Completed consumer satisfaction surveys; and
- Developed a clinical evaluation instrument.

Each year LaneCare has managed access and utilization carefully to maintain the service budget within total capitation. Year 6 began with LaneCare fiscally sound. Despite the budget challenges LaneCare will remain sound for this year. The projected expenses will be much closer to and may exceed predicted revenues in Year 6 and service utilization and the LaneCare budget will require greater monitoring. LaneCare initiated a comprehensive system review and strategic planning process during Year 5 that has resulted in significant improvements implemented effective October 1, 2002. Changes that are being implemented will reduce administrative costs and improve service delivery. These include:

- Reduced administrative staff;
- Streamlined care coordination;
- Secure Internet-based registration and self-authorization system so that data is entered directly by contracted providers;
- Improved hospital diversion resources;
- Contract agreements for accountability; and
- Case management partnership with LIPA.

LaneCare has not been able to offer reimbursement rate increases to most contractors for several years; this is true again this year. Most contractors are experiencing increased costs without being able to achieve an increase in revenues. LaneCare has achieved a remarkable partnership with providers that has allowed for open communication and shared decision-making. As budgets become tighter the tension between providers and LaneCare is likely to increase.

By April 2003, LaneCare and all contracted providers will need to be fully compliant with the new federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules. LaneCare is taking a lead in addressing some of the critical issues involved. This will require a major revision of contracts, member handbook, the provider manual, and policies and procedures. All service providers will be impacted. By October 2003, we will need to be fully compliant with the HIPAA transaction rules and code sets. There is a significant administrative cost in achieving compliance with the privacy rules.

It is possible that the entire OHP is in jeopardy as a result of the State's financial crisis. Medical costs continue to increase; the numbers of Oregonians eligible for OHP coverage has increased, as the economy has gotten worse and the cost of medications has skyrocketed. What a viable alternative might look like is not known at this time.

The Department of Health & Human Services, LaneCare and LCMH have proposed an innovative ***integrated full-service pilot project*** with the state Office of Mental Health and Addiction Services (OMHAS). We are currently engaged in preliminary negotiations with the state in having the County contract for and manage all behavioral health service funds for treatment of Lane County citizens. Lane County will have opportunities for expanded local clinical decision-making, increased flexibility of funds, and the ability to direct resources to meet critical needs. This will be balanced by County assumption of additional risk. See attachment (Elements of a Full Service Human Service Pilot Agreement).

VI. PUBLIC HEALTH SERVICES (Karen Gillette, Program Manager)

Communicable Disease Service Unit

The Lane County annual school immunization review was completed in mid-March. During this three-month effort, reports were received from 162 Lane County schools and 114 children's facilities. The immunization records of the more than 55,000 children involved in those programs were reviewed for completeness. In early February, after detailed immunization record searches between Lane County Public Health immunization staff

working in coordination with the schools, 3,249 "incomplete/insufficient" letters were issued and 527 students were found to have no available immunization record. By school exclusion day on February 20, 2003, all but 667 of the 3,249 records were complete. Of those children excluded from school until their immunization records were brought up-to-date, the vast majority was completed within a couple days. By day 12, all records were complete. Religious exemptions, which make-up 3% of the school population, were not included in the exclusion figures.

Such success in achieving these thorough rates of school age immunization are helped by the state-wide computerized ALERT system of reporting immunization information between private medical providers and the local health departments. Lane County Public Health has taken a leadership role in promoting ALERT participation in our communities. Last month, the Oregon Committee on Immunization Practice awarded Lane County Public Health, Katie Sauder (our VISTA volunteer), and Shirley Yoder (our public health immunization outreach nurse), the annual award for promotion and advancement of ALERT participation by private providers in Lane County.

Hepatitis A and B are serious communicable diseases present in our community. As a measure to reduce transmission, it has been an objective of public health programs, including Lane County, to offer Hepatitis A and B vaccinations to particularly high-risk groups, including clients in the sexually transmitted disease (STD) clinics and injection drug use service and treatment settings. Cost of the vaccine has been a prohibitive factor for people to receive the vaccinations. While the Hepatitis B vaccination is given to children from birth through 18, through the Vaccine for Children Program, access for adults has been limited to those who can afford to pay the high costs. It is exceptional for insurance companies to cover these costs and the Oregon Health Plan does not for most. Following mutual county, state and local community based organization efforts through the fall and early winter 2002, Hepatitis A and B vaccines became available at the end of January 2003 at no cost to local health departments. The vaccinations will be provided through a state pilot program which is to be used to immunize clients in those high-risk populations noted above. After developing procedures and coordination of efforts with other programs, Lane County Public Health began offering and administering Hepatitis A and B vaccinations in our Eugene STD clinics on April 1, 2003 to Lane County methadone clients, to Lane County Public Health clients at the Willamette Family Treatment Center, and through our partnership with HIV Alliance injection drug user outreach efforts.

Our HIV prevention program is moving forward to implement a "Rapid HIV Testing" pilot program. With the FDA approval in the Fall of 2002 of a new test called "OraQuick" (which will provide preliminary HIV test results within 20 minutes of testing), LCPH in conjunction with Lane County Corrections, HIV Alliance, Lane County Methadone Treatment Program, and Willamette Family Treatment Center are meeting to plan participation in the state sponsored pilot program. Due to the difficulty of getting people to return in two weeks for test results, this pilot project will allow us to provide results very quickly rather than waiting the two weeks. With preliminary results at the same time as testing, clients can receive referral to HIV care and treatment programs as well as specific counseling to reduce further transmission of the infection.

Our intensive daily efforts to prevent further transmission of tuberculosis at a Eugene homeless shelter and within the community continue. On average, we continue to receive one new case of tuberculosis every month. Our clients include those in the homeless shelters, among the foreign born, and from the community. The efforts at the shelter, while very labor intensive, have clearly prevented an almost certain significant increase of residents and staff being infected with the bacterium.

Lane County Public Health communicable disease staff has also focused attention on so-called "emerging diseases", such as SARS and West Nile Virus. Staff remains current on the process of identifying and reporting cases, as well as providing resource materials to other health care delivery teams in Lane County and the community at large.

Environmental Health Service Unit

The Environmental Health unit continues to find itself in the midst of numerous changes as a result of both internal and external forces. More retirements of key personnel in the past six months and the activity in the area of bioterrorism/preparedness have left us thin in being able to staff all needs. A sanitarian with more than thirty years of experience in our agency and the Public Health Engineer/Supervisor retired early in 2003. We have reassigned one sanitarian to the grant-funded bioterrorism/preparedness position and hired a new person to fill the position vacated by the reassignment. We are in the process of completing a position description questionnaire to more clearly define the duties, knowledge requirements and responsibilities of the supervisor in anticipation of filling that position.

Our main objective is to protect the health of residents and visitors in Lane County as they use our restaurants, hotels, public swimming pools, schools and other public facilities. Education of food handlers continues to be a priority, as prevention of disease transmission through improper food cooking, cooling, storing and serving remains a major goal of this unit. An increased awareness of bioterrorism/preparedness and diseases transmitted by vectors has resulted in more time spent on these newer issues and somewhat less on the issues of inspection and education. By integrating more with the communicable disease team, we can deal with all these issues in a professional manner while not neglecting our core issues relating to inspections of facilities frequented by the public.

Teen Pregnancy Prevention/Family Planning Unit

In the fall of 2002, Public Health's Family Planning Program, in conjunction with H&HS Administration, decided to move forward on a long planned transition to a computerized appointment scheduling and upgrade of our billing system. For several years, we have worked through Ahler's for coding and billing for clients in the Family Planning Expansion Project (FPEP). The new billing and scheduling services are the next step in improving the process. The software programs were installed in December 2002. Since then, we have had success with the billing program, thanks to the efforts of the Information Services Department in conjunction with Pam Stuver, Nursing Supervisor, and the Family Planning office assistants. The scheduling program remains a challenge and all parties are continuing efforts to get this up and functioning smoothly.

We have also restructured our clinic schedules in Eugene, Oakridge and Cottage Grove to mitigate staffing losses and to make more efficient use of nurse and nurse practitioner services. Our clinics have been busy and these transitions have challenged us all. The result has been improved efficiency and service to clients. Staff has participated in the details of changes so that it can work well for the team.

Breast & Cervical Cancer Screening Program

The Breast and Cervical Cancer Screening Program (BCCP) has been providing access to clinical breast exams, mammograms, Pap tests, pelvic exams and other diagnostic services to approximately 4,500 uninsured or underinsured men and women since its inception in 1997. Over the past six months we have screened approximately 460 clients, of which 10 were diagnosed with breast or cervical cancer. Detecting breast and cervical cancers early on increases the chance for survival. The BCCP is ensuring that many women and men in Lane County receive the care they need in time to save their lives.

Maternal Child Health Unit

Nurses on the Maternal Child Health (MCH) team continue to provide home visiting services to high-risk infants, children and pregnant women. Children with special health care needs are provided home visits through the CaCoon program. With grant funding, we also have nurses at the Willamette Family Treatment Center and Child Welfare Services for public health nursing functions primarily focused on maternal child health. The MCH team and Healthy Start core team have continued to work on coordinating referrals and providing technical assistance as needed to each other. The two programs also work closely with the WIC program for referrals and technical assistance to one another.

Healthy Start Unit

Healthy Start continues to offer support and education services to first-time families in Lane County through voluntary home visiting services. During the past six months, the program has expanded to include providing resource referral information to all Lane County families. Healthy Start has also begun to implement prenatal services and group components for both parents and children. These additions have been shown by research to enhance the positive outcomes of home visiting programs like Healthy Start.

The central administrative core of the program is housed under Lane County Public Health, with funding for the program coming through the state and local Commission on Children and Families. Service delivery is provided through seven contracting agencies throughout the county.

Healthy Start is a research-based primary prevention program that has been proven to effect positive changes in the lives of families and children. Currently, about 700 families countywide are engaged in the ongoing intensive home visiting program. These families have been determined to be at high risk for child abuse and neglect. Positive outcomes tracked in the Oregon Healthy Start Status Report for 2001-02 demonstrated a lower rate of child abuse and neglect, a higher rate of utilizing well-baby care by a primary care

provider, decreased emergency room use, and an increased rate of childhood immunizations in Healthy Start families. These families also read to their children more than the general population and reported that the program was helpful to them in their parenting.

Healthy Start is part of a comprehensive system of supports and services to all families in Lane County. Healthy Start offers Welcome Baby home visits to low risk families throughout the County, providing resource information and helping them to access services. Approximately 700 families per year receive visits.

Healthy Start has established a countywide network of playgroups, in collaboration with Family Resource Centers, community churches, and non-profit agencies. At these groups, parents receive support and education from staff, and are encouraged to develop networks of support among themselves, thus reducing the isolation that is a contributing factor in child abuse and neglect. They also have an opportunity to ask questions of the Healthy Start public health nurse related to health, safety, and nutrition, and to have their baby weighed. There are eight on-going playgroups throughout the county: Junction City, Oakridge, Florence, Springfield, Cottage Grove, River Road in Eugene. There are also groups for teen parents, parents with cognitive limitations, and Spanish monolingual families.

Healthy Start actively promotes car seat safety by holding car seat classes and clinics, staffing the car seat information line, and playing a pivotal role in coordinating car seat services through the Lane County Car Seat Consortium. Oregon Department of Transportation and ACTS of Oregon, as well as United Way of Lane County, provide support for these activities.

In collaboration with the MCH unit, Healthy Start is offering prenatal home visiting services for first-time pregnant women in our county. Through this collaboration, the support and education begun during pregnancy continues with a seamless transition to Healthy Start at the birth of the child, and pregnancy outcomes are improved.

Healthy Start sponsors parenting classes and groups throughout the county, including "Baby Blues" for those suffering from post-partum depression, research based "Making Parenting a Pleasure" groups in rural areas, and parenting skills classes emphasizing positive discipline.

Currently, respite childcare and therapeutic classroom slots are available in a pilot project through our partner agencies for Healthy Start families.

Women, Infants and Children Unit

In February 2003, the Women, Infants, and Children (WIC) Program was serving 8,500 clients. The number of vouchered participants (the actual number of participants redeeming WIC vouchers for that month) was 7,826. For this program year, the assigned target vouchered caseload level is 8,228 vouchered participants per month. The program is currently maintaining at 95.1% of this assigned caseload due to recent losses of trained staff. Additional clinic efficiency measures have been implemented to keep the decline in

caseload to a minimum. During this period, client requests for service have maintained at a very high level. Since January 2003, it has been difficult to maintain an adequate number of appointment slots. However, there is currently no waiting list for services.

WIC nutrition education offered in the Spanish language is no longer offered in the home setting through the Extension Service. Instead, all Spanish WIC nutrition education classes are now held in the WIC offices in Eugene and Cottage Grove. The demand for these classes has increased, which created the need for a greater selection of class topics and more efficient delivery of nutrition education by utilizing a group class setting.

Tobacco Prevention Unit

The latest data from the Oregon Department of Human Services/Health Services on tobacco use by Oregonians shows that the Tobacco Prevention and Education Program is quite successful. Since the inception of the statewide program in 1996, there are 75,000 fewer adult smokers, 25,000 fewer youth smokers, 2,200 fewer pregnant smokers, 1.5 billion fewer cigarettes sold annually and 60,000 fewer adult users of smokeless tobacco. Additionally, approximately 95% of Oregon's workforce is protected from exposure to secondhand smoke in the workplace. Over 40,000 Oregonians have called the toll-free tobacco quit line for help with cessation needs.

Local tobacco prevention staff is engaged in ongoing education regarding Eugene's clean indoor air ordinance, the Statewide Smoke Free Workplace Law and state and local age of sale laws. The Tobacco Free Lane County coalition continues to meet on a monthly basis and produce a bi-monthly newsletter entitled "Tobacco Free Times."

During the past several months, tobacco prevention staff/contractors and volunteers completed the following projects:

- Outreach to dental community on assisting patients to quit tobacco.
- Oakridge Mayors Youth Advisory Council worked with the Oakridge City Council to pass a youth access ordinance (passed in March 2003), which will license tobacco retailers and provide penalties to license holders who sell tobacco products to minors.
- Outreach to U of O students about the tobacco industry's efforts to addict the college age population and influence public opinion regarding their image. The Tobacco Prevention Program provided the student organized U of O Law conference with two speakers who educated participants on how the tobacco industry impacts the environment.
- Surveyed Lane County food and beverage businesses and other workplaces about their feelings/needs around the recently implemented Clean Indoor Air Laws.

Despite all of the progress made by the statewide tobacco prevention program, we received word in early March that the legislature had made the decision to temporarily suspend the program and use its funds to help deal with the current state budget crisis. As of April 5, 2003, the local tobacco prevention program will temporarily shut down. The

tobacco prevention coordinator will be on a very minimal temporary help status to ensure that people needing assistance with the various tobacco laws have their needs met.

Obesity

At the previous Board of Health meeting, a request was made that Public Health make a comment on obesity in our state and community. Obesity is not something we track for the community, but we do have some state statistics provided by Dr. Mel Kohn, State Epidemiologist for the Oregon Department of Human Services/Health Services.

According to Dr. Kohn, obesity is on the rise in the State of Oregon. He states in the Fall 2002 issue of Oregon's Future, "In the past ten years obesity among Oregon adults has doubled from 11% to 22%. Oregon – and Alaska – has the dubious distinction of being the first states west of the Rockies to have a prevalence of obesity greater than 20%. Oregon's children are particularly in trouble: 28% of 8th grade students and 21% of 11th grade students are currently overweight."

Further, the Centers for Disease Control estimate that 300,000 deaths occur in the U.S. each year due to obesity, which is second only to the 400,000 deaths, which are associated each year with tobacco use.

The two major contributors to the increase in obesity in our state and the nation are the changes in the types and amounts of foods eaten and the decrease in physical activity. People are "on the go" and tend to eat out more often, many times at places where healthy food choices are more limited. We also have the option of super sizing our portions.

In regards to physical activity, we have more labor saving devices and tend to sit more watching TV and working at computers. In Oregon's Future, it is noted that the Surgeon General, the CDC and the American Heart Association, "all recommend at least 30 minutes of moderate physical activity, five or more days a week. Only 28% of Oregon adults meet that recommendation. Twenty-one percent of Oregon adults report no leisure-time physical activity at all."

Within our Family Planning and WIC programs at LCPH, we talk with our clients regarding their nutrition status and encourage healthy eating as well as physical activity. For example, within the WIC program, clients are coded as "at risk for obesity" and/or "obesity" which doesn't mean they are obese. Further assessment and evaluation are necessary for that diagnosis, and only the private medical physician can make the diagnosis. For children, the local WIC program currently has 21% of the caseload coded as either "at risk for obesity" and or "obesity". This represents 1,220 children out of a total of 5,835. For adult women, currently 40% of the caseload is coded as "overweight prepregnancy" or "overweight postpartum." This represents 724 women out of a total of 1,811; see attachments.

Dental

At the previous Board of Health meeting, we were asked to comment on the dental problems in Lane County. Through our MCH home visits and WIC program, we know that many children are presenting with dental problems which families cannot attend to due to financial constraints. We also know that if a family is able to access the dental clinic at White Bird or is finally able to obtain dental services with coverage through the Oregon Health Plan, children and adults are presenting to the dentist with multiple dental problems.

Recently, the WIC Coordinator and our Vista worker have been talking with the local Head Start health consultant regarding a grant opportunity for children enrolled in WIC to receive fluoride varnishing. This would help decrease the frequency of bottle rot syndrome and increase the overall dental health of both the WIC and Head Start children. See attachments.

VII. ALCOHOL/DRUG/OFFENDER PROGRAM (Linda Eaton, Program Manager)

DUII/Corrections

The number of new DUII evaluations continues at a steady, if not higher, level. The numbers for the last several months are listed below, and compared with the same month in the previous year.

Month	**New Evaluations (2002/03 Evaluations)**	**New Evaluations (Previous Year)**
March	190	149
February	170	167
January	191	155
December	165	138
November	146	147
October	177	157
September	148	121
TOTALS	**1,187**	**1,034**

In the same seven-month period, other evaluations were lower, as shown below. These evaluations are mainly for domestic violence offenses and drug charges other than DUII.

Month	**New Evaluations (2002/03 Evaluations)**	**New Evaluations (Previous Year)**
March	36	27
February	29	43
January	20	37
December	39	36
November	23	40
October	37	52
September	32	41
TOTALS	**216**	**276**

In November 2002, the program began a new policy of requiring full payment for the evaluation at the time of service. Payment plans were eliminated. This has resulted in higher monthly fee collections. In spite of this, however, we have budgeted to eliminate one Mental Health Specialist position in July, in order to balance next year's budget.

As mentioned in the last Board of Health report, the amount of state funding for indigent DUII treatment has been reduced. The new funding allocation will be combined with other state funding for outpatient A&D treatment. A Request for Proposals process will be conducted this spring for DUII treatment providers.

The DUII/Corrections unit has been affected by funding cuts and layoffs, along with many other programs. While no position has been eliminated this year, one Mental Health Specialist was laid off due to low seniority, and another employee from within the department took his place. The expectation of more staff changes in the future creates on-going uncertainty.

Sex Offender Treatment Program

This program has been affected by reductions in Community Corrections (CCA) funding. Funds have been reduced in this fiscal year by $52,215. As a result, fourteen treatment slots have been eliminated, and family treatment services have been significantly reduced. We have also discontinued pre-sentence sex offender evaluations for Circuit Court. One Mental Health Specialist position has been cut.

The future of CCA funding for next year is uncertain. Even with the same (reduced) amount of funding, the program will make a further reduction in Mental Health Specialist (MHS) FTE next year, in order to meet rising expenses.

To increase revenue from client fees, and to incorporate the implied policy of the Supervisory Authority Team, the program will make changes in the client sliding fee scale effective July 1. The effect of these changes will be to increase the cost of treatment for most offenders at the lower end of the fee scale. We will attempt to retain lower fees for those who need them the most, e.g., offenders on disability who have limited income. The policy discussions about sex offender treatment in the last few months reflect a belief that offenders should pay more for their treatment.

The impact of these service reductions includes fewer offenders served in the program, and possibly an under-supply of low-cost treatment slots in the community. Although some offenders may be able to pay more for treatment, several factors limit their potential to do so. Those include a poor economy, fewer well-paid jobs, employers' tendency to not hire felons in an "employers' market," and characteristics of offenders, such as low employability, long histories of incarceration, etc.

There will also be an impact from the reduction of family treatment services. The MHS position eliminated this year was the family therapist, due to seniority. As a result, services such as the family education group will be eliminated. Family education and support are crucial to the offender's success in treatment. Often, family members are in denial regarding the offender's criminal history and level of risk to re-offend. They may not

understand what sex offender treatment is, and the purpose of many of the restrictions placed on offenders, especially in the early phases of treatment. Past surveys of family members have been very positive regarding the benefits of family group, with participants reporting an appreciation for the service, and a greater understanding and support for treatment.

Another function of family group has been to train family and friends as community and family "supervisors" for offenders in treatment. The availability of a trained and approved supervisor to accompany offenders on community outings allows the easing of restrictions as offenders make progress in treatment. For families who are preparing to unite or re-unite, it is critical to have the offender's partner be a trained and approved supervisor. It is too early to know the exact impact of eliminating these services, but it will undoubtedly be a negative impact on treatment.

The funding cuts and resulting staff changes have had a significant impact on the morale of program staff. Two of the five Mental Health Specialists were laid off. Another employee from within the department has filled one of those positions. However, that position will be reduced to half time in July. In spite of the difficulty of these losses, the staff continues to work hard and provide high-quality treatment services.

Methadone Treatment Program

In January, the methadone treatment program admitted 25-30 transfer patients from the CODA program, which closed on January 31, 2003 due to the cut in chemical dependency benefit for OHP Standard members. All of these transfer patients are covered by OHP Plus, which does retain the chemical dependency benefit, at least for the current biennium.

By the end of January, we had a total of 145 patients in the program. As of April 4, we have 137 in the program. On March 1, about 50 of our patients who had OHP Standard coverage lost their benefit, and became self-pay patients. As of April 1, six of those patients had left the program due to inability to pay. Several more will probably leave during the month of April.

The program adopted a new fee scale in January to make up for lost OHP revenue. Rather than charge fees according to the department's sliding fee scale, we have a flat monthly fee of $225, or $200 if paid by the fifth of the month. (This is a change in the fee scale, as opposed to a change in the actual fees.) This resulted in increased costs for some patients, lower costs for a few, and an overall increase in fee revenue for the program.

The changes as a result of OHP cuts have been a huge challenge for our program over the last several months. The anxiety level is very high on the part of patients worried about whether they can stay in treatment, and what will happen to them if they can't. The sudden influx of many new patients in short period of time has been a challenge for staff and patients alike. The OHP Plus patients from CODA, as a group, have a complex set of needs and impairments, including physical and mental disabilities in addition to their opiate addiction. They require a high-level of case management and crisis intervention, which stretches program resources to the very maximum. As stated above for the Sex Offender

Treatment Program, the Methadone staff has worked hard to continue providing high quality services during this transition period.

VIII. COMMUNITY CORRECTIONS, ADULT PAROLE & PROBATION (Grant Nelson, Program Manager)

As predicted by the State Department of Administrative Services, our supervised offender population in Lane County has continued to grow. As of March 17, 2003 Community Corrections supervises 3,514 individuals. Over 10% of our current workload consists of misdemeanor cases not funded by the State, mostly misdemeanant sex offenders and misdemeanant domestic violence offenders. Although we presently supervise these offenders because of the significant risk they pose to the safety of the community, we may be forced to eliminate misdemeanor supervision or reduce current supervision levels for felons in the near future due to budget cuts and staff reductions.

In February 2003 Community Corrections regrettably closed the Springfield station as the new building owners chose not to renew our office lease agreement. An attempt to secure another lease within Springfield failed due to budgetary constraints. Both parole and probation officers, including one bilingual officer, were relocated to downtown Eugene. Community Corrections is committed to the goal of closer connections to the neighborhoods and communities in Lane County and will continue to seek options for outreach in the Springfield area.

The Day Reporting Center services unfortunately have been limited to reporting and job search monitoring until additional resources are identified and available. Nevertheless, accomplishments with existing resources have proven to significantly contribute to offender control and accountability. The Day Reporting Center assists 23% of those referred to achieve employment as well as offering increased structure that significantly contributes to positive changes in the lives of offenders.

State law requires the acquisition of DNA samples from all convicted felons and certain misdemeanants. Numerous previously unsolved open cases in Oregon have been resolved because perpetrators were identified by means of DNA sample comparisons to DNA evidence discovered as part of criminal investigations. Community Corrections contributes approximately 80 buccal cheek cell swabs each month to the DNA database which promises to become as important in the field of criminal investigations as fingerprints.

Community Corrections has recently arranged with the Circuit Court and the District Attorney to issue supervisory authority arrest warrants for probation violations using the same guidelines as currently exists for offenders on post prison supervision. This new procedure results in a swifter administration of justice and reduced crowding of the Lane County Circuit Court docket. Offenders are diverted from court and offered structured sanctions or jail time for their violations by Community Corrections Hearings Officers. Offenders have the option to accept the sanction recommended by the Supervising Officer or appear in court for adjudication of the violation allegation(s).

In an effort to integrate Lane County's community corrections system and maximize the available resources, Community Corrections is working with Lane County Adult Corrections to develop a plan to improve jail population management. By increasing Community Correction input on the matrix release of offenders sanctioned or arrested on supervisory authority warrants we hope to achieve increased community safety at a reduced cost.

In November 2002 the Board of County Commissioners approved the creation of the Supervisory Authority Team (SAT). Grant Nelson, Community Corrections Manager was appointed as a member along with John Clague, LCSO Corrections Captain and the Honorable Karsten Rasmussen, Chief Criminal Judge Lane County Circuit Court. The SAT purpose is to coordinate the supervision of sentenced felony offenders and to recommend the wise use of available resources to enhance public safety. The first order of business for the SAT was to formulate a recommendation amending Lane County's portion of the Community Corrections Act (CCA) budget to accommodate cuts in State funds. Community Corrections is almost exclusively funded by CCA allocations and should expect the reductions to dramatically impact service levels.

Community Corrections, in cooperation with the Commission on Children & Families, the Sheriff's Office, Circuit Court and Womenspace, agreed to participate in and seek grant funding for a "Victim Safety through Enforcement of Protective Orders and Intensive Supervision" initiative. Our focus as in the previous year's pretrial monitoring pilot project remains on coordination of provider response and monitoring compliance with pre-trial release agreements which usually include a no-contact with victim condition, often include no weapons provisions, and requirements regarding future appearances in Court. The partners mutually agree that while enforcement of protective orders is central to improving family safety during the crisis precipitated by an incident of domestic violence, the long term prognosis for family victim safety can be further improved by offender change through a combination of supervision, accountability, and batterer intervention programming.

The National Council of Juvenile and Family Court Judges recently recognized Community Corrections' innovative approach to domestic violence pretrial monitoring services. In March the Community Corrections Program Manager and pretrial Parole Officer presented the pilot project findings to the 30th National Conference on Juvenile Justice in Philadelphia.

The Community Corrections Manager is also representing Lane County in the *Greenbook* Policy Advisory Committee. GPAC supports communities that are engaged in the implementation of the *Greenbook* recommendations by providing critical thinking and policy strategies in order to promote safety, well-being, and economic and social stability for those experiencing family violence.

The agency continues its partnership with the County's Department of Youth Services, the Alcohol, Drug, and Offender Treatment Program and Lane Council of Governments in a planning grant to provide improvements to policies and procedures as well as the practices concerning the supervision of sex offenders. We expect this process to extend over several years and build on the solid foundation of effective supervision and treatment of sex offenders that exists in Oregon.

Along with other Lane County programs, Community Corrections is working to increase office security. In March 2003 we implemented a new emergency shutdown procedure, employee and volunteer identification badge requirement, additional shipment receiving measures and are currently working on a comprehensive Emergency Action Plan for the State Office Building.

The criminal justice system and the human services systems in Oregon continue to be staggered by revenue shortfalls at the state level. Most of the resources that support the supervision, sanctions and services required to safely manage offenders who are in the community on probation or parole come from the State of Oregon. The 5th Special Session of the Legislature concluded its business late last year leaving voters with a choice to either raise income taxes or see deep cuts in human services and in the criminal justice system. The voters chose not to increase taxes and this division was faced with the prospect of reducing supervision staff by more than 25% with no decrease in the number of offenders requiring supervision. Following on the heels of that cut, revenue shortfalls in November and December of 2002 had to be absorbed as well. Caseload sizes have continued to increase while the ability of staff to do the proactive one-on-one work we are trained to do, and that contributes significantly to community safety, continues to be degraded. As a result of these cuts and the prospect of continuing resource problems, the County is seriously contemplating returning responsibility for managing offenders supervised in the community to the State of Oregon.

The next two years promise great challenges for all of us in the criminal justice system. This writer is sure that those of us who remain after layoffs and early retirements will do their very best to insure the safety of the community.

Attachments: Elements of a Full Service Human Service Pilot Agreement
Obesity Information
Dental Information

Elements of a Full Service Human Service Pilot Agreement Between the State of Oregon and Lane County, Department of Health & Human Services (H&HS)

Pilot Project Goal

To create a pilot project to evaluate whether Lane County can maximize the efficient and effective delivery of behavioral health services through enhanced local planning, coordination and prioritization of federal, state and local funds. Specifically, can aggregating various behavioral health-funding streams through a broad County contract (block-grant type agreement) achieve administrative savings, enhanced utilization management, increase Medicaid funding, and improved local service coordination?

- Optimize local management of a maximum amount of state funds, state-administered funds (Medicaid, federal mental health and addictions Block Grants, other federal or state grant resources), and local funds.
- County assumes additional financial and treatment/support responsibilities for Lane County's children, adults and older adults with mental health and/or addiction disorders and promotes local service prioritization and service provision that are less restrictive and more affordable than those currently available.
- Determine minimum level of funding necessary to maintain basic behavioral health functions in Lane County.
- Provide good quality data and reporting to the State Task Force on improving mental health services (SB 541).

General Agreement

The State will contract with Lane County combining all agreed upon state and federal financial resources calculated to be available through the 2003-05 biennium in the Legislatively Approved Budget targeted for the treatment, safety, support, and prevention needs of Lane County residents within negotiated financial and performance outcome measures.

- State will agree to fund the pilot project for a minimum of four years at the negotiated funding levels to provide Lane County time to thoroughly evaluate its efficacy.
- Lane County will identify system issues related to integration and the development of related strategies and help the State to disseminate successful elements of the pilot project to other County or regional delivery systems statewide.

Primary Risk Areas

Resources available for Lane County will include all state General Fund (matched and unmatched), state Lottery dollars, and federal funds (e.g., Medicaid, Block Grant, Medicaid Upper Payment Limit) for specified state hospital, community extended and enhanced care, residential, employment, acute care services, mental health, drug and alcohol treatment, problem gambling treatment, and prevention services for addiction and problem gambling projected to be needed for Lane County residents in those primary risk areas for which Lane County and the State reach mutually acceptable risk arrangements. Agreements could be negotiated in any or all of the following primary risk areas:

a) Child and adolescent (ages 0-17 years) mental health services.
b) Adult mental health services (including all pre-commitment and civil commitment services).
c) Forensic behavioral health services (including all or specified criminal commitment services).
d) The state's Psychiatric Security Review Board must be a party to agreement in this primary risk area.
e) Geropsychiatric mental health services (ages 65 and above).
f) Adolescent alcohol and drug treatment.
g) Adult alcohol and drug treatment.
h) Alcohol/Drug Prevention: universal, selective and indicated.
i) Behavioral health pharmacy / medication benefits (for selected other primary risk areas).
j) Gambling addiction prevention.
k) Gambling addiction treatment services.

Agreements would include at least the following components:

a) Specification of the risk arrangement (full, partial or none);
b) The types and minimum / maximum amounts of funding available;
c) Minimum performance outcomes; and
d) Applicable administrative requirements (OARs, federal requirements, contractual, any required variances, etc.).

Evaluation of Pilot Project

Evaluation components will include both internal (degree to which financial and performance outcomes are achieved) and external (to be determined by consensus process between an independent research center and State,

County, and key stakeholders such as consumers, families, community partners, and other related state agencies).

- Research funds will not be drawn from service funds nor passed on as an unfunded administrative expectation.
- Progress reports submitted to State every six (6) months.
- After two (2) years, based on the outcome evaluation, State and County will meet and determine the components of the pilot project that are effective and efficient. Continued or enhanced funding will be based on success.

Principles

A) The more risk assumed by County, the more resources and flexibility will be extended by the State.
B) To the degree administrative costs are reduced, service funds will be preserved or increased accordingly (built-in incentive).
C) Contracts should be based on historical cost and utilization trends with a 100% shift of service funds to Lane County for assuming service responsibility and financial risk.
D) Formulas used to determine costs will be mutually agreed upon by both Lane County and the State. These formulas, costs, and utilization trends will be reviewed and adjusted if necessary biannually.
E) Funding levels or service expectations will not be changed without mutual agreement and contract amendments.
F) Necessary funding reductions will result in reduced service expectations. Funding for this project will not fall below the negotiated baseline for maintaining the project.
G) Contracts and agreements can be altered, reformed, or discontinued by either party with reasonable (to be determined) formal notice.
H) County must maintain a commitment to protection of public safety and rights of consumers and families.
I) Partnership between State and County means working through issues and problems in an open and direct manner.
J) The pilot project is not designed to "siphon" funds from: prevention to treatment, alcohol/drug treatment to mental health treatment, from mental health to A&D treatment, from children's services to adult services, nor from adult services to children's services. Blended funds will be used to develop a flexible system with a local shared management/governance to create an integrated system of care that is responsive to community needs assessments and community planning.

K) Lane County will not be excluded from any increases in mental health/addiction funds, should they be granted through the state budget and will be included in all State approved cost of living adjustments.

L) The pilot would allow for the purchase of specialized or statewide services not available in Lane County for Lane County residents with Full Service funds.

Background

- The need in Lane County for this pilot project is great. Behavioral health funds available to support a minimum, locally delivered service system must be preserved.
- Lane County has a long history of developing strong local service resources to meet the mental health and chemical dependency needs of youth, families and adults. LaneCare is currently contracting with fourteen (14) outpatient, non-profit providers of mental health services. Lane County H&HS currently contracts with nine (9) providers for alcohol and drug treatment services.
- Lane County also has a rich history of coordinated prevention efforts. Lane County H&HS currently supports six (6) community-based prevention coalitions, school-based prevention and contracts with several non-profit agencies to provide prevention-focused services.
- Lane County has a long history of partnerships and collaborations with the State and with OMHAS, and has implemented many successful programs and service components to address unmet mental health needs. This pilot project is a natural extension of these positive efforts.
- System inefficiencies are maintained as many mental health services are managed directly by the State or contracted separately from the Mental Health Organization (MHO).
- Behavioral health services have been difficult to coordinate as drug and alcohol treatment funds are separate from MHO mental health funds.
- System inefficiencies are maintained as many mental health and chemical dependency service funds remain in other governmental agency budgets requiring complex system management and opening the possibility of "client dumping."
- Administrative rules and requirements have become an excessive burden and lower productivity for contracted providers.

Service System Goals

- Establish an integrated and coordinated human service system in Lane County.
- Provide enhanced quality and accessible County-based behavioral health services for children and adults.
- Maintain clients within their community in the least restrictive environment.
- 50% of Lane County residents in the State Psychiatric Hospital will be returned to Lane County within one year.
- Lane County Health & Human Services will work with the Lane County Sheriff in developing a local Forensics unit.
- Lane County will develop a rapid response step-up/step-down capacity for individuals experiencing a mental health crisis.
- Lane County will maximize the provision of wrap-around supports and community supports for persons with a serious and persistent mental illness.
- Lane County will develop a local crisis stabilization, assessment program for youth, ages 12 and older.
- Lane County will contract with providers for much of its behavioral health services.
- Achievement of positive treatment outcomes through increased flexibility of local programs, implementation of best practice technologies, integration of behavioral health services into a broad quality management system.
- Institute result-based contracting.
- Maximize services through inclusive partnerships with private and public entities and increased federal Medicaid match to local funds.
- Establish monthly meetings of a local steering body that includes public agency directors (Health & Human Services, Department of Human Services, Oregon Youth Authority/Department of Youth Services, Senior and Disabled Services, LaneCare, etc.), contractors, and consumers.
- Meet quarterly with local private funding entities (e.g., United Way, 20-30 Club, Rotary Club) to coordinate community-funding strategies.

- Enhance existing prevention efforts established through alcohol and drug prevention funds through greater collaboration of pilot partners.

Expanded and Integrated Human Service System

Lane County has expressed an interest in developing a behavioral health pilot program that will integrate and coordinate system components, blending and braiding funding, resources and services. Lane County Health & Human Services currently manages Mental Health, Alcohol/Drug/Offender Services, Parole and Probation, Public Health Services (including Healthy Start and WIC), and Developmental Disabilities. Some service coordination is currently occurring among these programs.

There may be opportunities to further integrate State managed services with the full service behavioral health pilot project. As examples:

- Lane County has submitted a proposal for a Federally Qualified Health Center and expects to be approved with implementation completed during January 2004. This will encourage further collaborations between the MHO and the Fully Capitated Health Plan (FCHP). The Lane County Targeted Medication Case Management Project has developed an infrastructure and relationships that are functional and have resulted in a very powerful system analysis.
- The County has considered integrating the Commission on Children and Families (CCF) with H&HS. H&HS and CCF currently have an excellent working partnership. The LaneCare Manager is currently a CCF Commissioner. LaneCare and the CCF have co-sponsored the development and support for a Family Advisory Committee.
- Lane County H&HS collaborates with the Lane County CCF routinely. Through implementation of SB 555 and developing the Alcohol & Drug Prevention Plan for 2003-2005, Lane County H&HS will allocate prevention funds to the CCF to help build capacity of the local Family Resource Centers to provide services to children of alcoholics/addicts and their families.
- Senior and Disabled Services (SDS) have had a representative on the LaneCare Operations Council since the inception of the MHO. There are very positive relations between the County and SDS.
- The state Department of Human Services Service Delivery Area Manager is also on the LaneCare Operations Council and there are several examples of co-funded services for youth and families. For instance, treatment foster care and a crisis stabilization program are maintained through blended funds. The LaneCare manager is on the DHS SDA Advisory Committee.
- A potential infrastructure for building a governance structure for expanded community collaboration already exists. For the past seven (7) years,

monthly, half-day meetings have occurred to plan and coordinate the local system of care for children and families. This has been a very productive group. Membership has included:

- Director, Health & Human Services
- Manager, LaneCare
- Director, Commission on Children and Families
- School Superintendent
- 2 Directors, School Special Education
- Assistant Superintendent, Lane Educational Special District
- Executive Director, United Way of Lane County
- Manager, Human Services Commission
- Manager, DHS CHS Services Delivery Area 5
- Director, Lane County Early Intervention
- Director, Non-Profit Provider Agency
- Director, Department of Youth Services
- Manager, Lane Council of Governments

Last Revision Date - April 15, 2003

Overweight and Obesity

Defining Overweight and Obesity

Overweight and Obesity Among Adults

Recent results of the National Health and Nutrition Examination Survey (NHANES) 1999 indicate that an estimated 61 percent of U.S. adults are either overweight or obese, defined as having a body mass index (BMI) of 25 or more.

- Among U.S. adults aged 20-74 years, the prevalence of **overweight** (defined as BMI 25.0–29.9) has increased an estimated 2 percent since 1980, increasing from 33 percent to the 35 percent of the population in 1999 (based on NHANES II and NHANES 1999 data).
- In the same population, **obesity** (defined as BMI greater than or equal to 30.0) has nearly doubled from approximately 15 percent in 1980 to an estimated 27 percent in 1999.

Overweight

Overweight refers to increased body weight in relation to height, when compared to some standard of acceptable or desirable weight (NRC p.114; Stunkard p.14). **NOTE:** Overweight may or may not be due to increases in body fat. It may also be due to an increase in lean muscle. For example, professional athletes may be very lean and muscular, with very little body fat, yet they may weigh more than others of the same height. While they may qualify as "overweight" due to their large muscle mass, they are not necessarily "over fat," regardless of BMI.

Desirable weight standards are derived in a number of ways:

- By using a mathematical formula known as Body Mass Index (BMI), which represents weight levels associated with the lowest overall risk to health. Desirable BMI levels may vary with age.

- By using actual heights and weights measured and collected on people who are representative of the U.S. population by the National Center for Health Statistics. Other desirable weight tables have been created by the Metropolitan Life

Insurance Company, based on their client populations.

These sources are consistent with the U.S. Dietary Guidelines and with the National Heart, Lung, and Blood Institute's Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.

Obesity

Obesity is defined as an excessively high amount of body fat or adipose tissue in relation to lean body mass. (NRC p114; Stunkard p14) The amount of body fat (or adiposity) includes concern for both the distribution of fat throughout the body and the size of the adipose tissue deposits. Body fat distribution can be estimated by skinfold measures, waist-to-hip circumference ratios, or techniques such as ultrasound, computed tomography, or magnetic resonance imaging.

Individuals with a BMI of 25 to 29.9 are considered **overweight**, while individuals with a BMI of 30 or more are considered **obese**.

Overweight and Obesity Among Children and Adolescents

- The percentage of children and adolescents who are defined as overweight has more than doubled since the early 1970s.
- About 13 percent of children and adolescents are now seriously overweight.

In spite of the public health impact of obesity and overweight, these conditions have not been a major public health priority in the past. Halting and reversing the upward trend of the obesity epidemic will require effective collaboration among government, voluntary, and private sectors, as well as a commitment to action by individuals and communities across the nation.

Obesity Trends Among Children and Adolescents

Body Mass Index (BMI)

BMI is a common measure expressing the relationship (or ratio) of weight-to-height. It is a mathematical formula in which a person's body weight in kilograms is divided by the square of his or her height in meters (i.e., wt/(ht) 2. The BMI is more highly correlated with body fat than any other indicator of height and weight (NRC p563).

For more information on BMI visit:

Body Mass Index for Adults

Body Mass Index-for-Age (Age 2 to 20 years)

BMI Calculator

Individuals with a BMI of 25 to 29.9 are considered **overweight**, while individuals with a BMI of 30 or more are considered **obese**.

What BMI levels are risky?

According to the NIH Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, all adults (aged 18 years or older) who have a BMI of 25 or more are considered at risk for premature death and disability as a consequence of overweight and obesity. These health risks increase even more as the severity of an individual's obesity increases.

Waist circumference

Waist circumference is a common measure used to assess abdominal fat content. The presence of excess body fat in the abdomen, when out of proportion to total body fat, is considered an independent predictor of risk factors and ailments associated with obesity.

What waist size is risky? Undesirable waist circumferences differ for men and women.

- Men are at risk who have a waist measurement greater than 40 inches (102 cm)
- Women are at risk who have a waist measurement greater than 35 inches (88 cm)

How to measure waist circumference:
With a tape measure, comfortably measure the distance around the smallest area below the rib cage and above the umbilicus (belly button).

How to measure hip circumference:
With a tape measure, comfortably measure the distance around the largest extension of the buttocks.

NOTE: If a person has short stature (under 5 feet in height) or has a BMI of 35 or above, waist circumference standards used for the general population may not apply.

Waist-to-hip ratio (WHR)

Waist-to-hip ratio (WHR) is the ratio of a person's waist circumference to hip circumference, mathematically calculated as the waist circumference divided by the hip circumference. For most people, carrying extra weight around their middle increases health risks more than carrying extra weight around their hips or thighs. (NOTE: Overall obesity is still more risky than body fat storage locations or waist-to-hip ratio.)

What waist-to-hip ratio is considered risky?
For both men and women, a waist-to-hip ratio of 1.0 or higher is considered "at risk" or in the danger zone for undesirable health consequences, such as heart disease and other ailments connected with being overweight.

For a thorough discussion of waist circumference and its relationship to disease, read "Chapter 4: Treatment Guidelines" of the NIH Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.

What is a good waist-to-hip ratio?
For men, a ratio of .90 or less is considered safe.
For women, a ratio of .80 or less is considered safe.

References

Stunkard AJ, Wadden TA. (Editors) *Obesity: theory and therapy, Second Edition.* New York: Raven Press, 1993.

National Research Council. *Diet and health: implications for reducing chronic disease risk.* Washington, DC: National Academy Press, 1989.

National Institutes of Health. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults.* Bethesda, Maryland: Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 1998.

This page last updated September 05, 2002

United States Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Nutrition and Physical Activity

Overweight and Obesity

Frequently Asked Questions (FAQs)

How many American adults are overweight or obese?

- In 1999, an estimated 61 percent of U.S. adults were either overweight or obese, defined as having a body mass index (BMI) of 25 or more.
- In 2000, a total of 38.8 million American adults met the classification of obesity, defined as having a body mass index score of 30 or more.

To read more about American adult overweight and obesity trends, visit

CDC, Nutrition and Physical Activity, *Obesity and Overweight: Obesity Trends*
http://www.cdc.gov/nccdphp/dnpa/obesity/trend/index.htm

CDC, Nutrition and Physical Activity, *Obesity and Overweight: Body Mass Index (BMI)*
http://www.cdc.gov/nccdphp/dnpa/obesity/bmi.htm

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How many American children are overweight or obese?

- Today there are nearly twice as many overweight children and almost three times as many overweight adolescents as there were in 1980.
- Results of the National Health and Nutrition Examination Survey (1999) showed that 13 percent of children and adolescents were overweight.

To read more about childhood and adolescent overweight and obesity, visit

CDC, Nutrition and Physical Activity, *Obesity and Overweight: Trends*
http://www.cdc.gov/nccdphp/dnpa/obesity/trend/index.htm

National Center for Health Statistics (NHANES), Prevalence of Overweight Among Children and Adolescents: United States, 1999
http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity, Overweight Children and Adolescents
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm

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What is the difference between overweight and obese?

- An adult is considered "overweight" when he/she is are above a healthy weight, which varies according to a person's height. An individual is overweight when their BMI is between 25–29.9. The standard used by researchers to define a person's weight according to their height is "**body mass index**" (BMI).
- An adult with a BMI of 30 or more is considered obese. For example, for a 5'4" woman, this means that she is 30 or more pounds over her healthy weight.

To calculate your BMI and read more about the difference between overweight and obesity, visit

CDC, Nutrition and Physical Activity, *Obesity and Overweight: Body*

Mass Index (BMI)
http://www.cdc.gov/nccdphp/dnpa/obesity/bmi.htm

CDC, Nutrition and Physical Activity, *Obesity and Overweight: Defining Overweight and Obesity*
http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm

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Why are so many people overweight or obese today?

There are a number of factors that influence overweight or obesity, including

- Behavior—eating too many calories while not getting enough physical activity.
- Environment—home, work, school, or community can provide barriers to or opportunities for an active lifestyle.
- Genetics—heredity plays a large role in determining how susceptible people are to overweight and obesity. Genes also influence how the body burns calories for energy or stores fat.

Behavioral and environmental factors are the main contributors to overweight and obesity and provide the greatest opportunities for prevention and treatment.

To read more about the reasons for overweight and obesity, visit

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity, Overweight and Obesity at a Glance
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_glance.htm

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity, Overweight Children and Adolescents
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm

CDC, Office of Genetics and Disease Prevention, *Obesity and Genetics: A Public Health Perspective*
http://www.cdc.gov/genomics/info/perspectives/obesity.htm

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How does overweight and obesity affect your health?

If you are overweight, you are more likely to develop health problems; such as,

- heart disease
- stroke
- diabetes
- cancer (such as colon cancer, endometrial cancer, and postmenopausal breast cancer)
- gallbladder disease
- sleep apnea (interrupted breathing during sleep)
- osteoarthritis (wearing away of the joints)

The more overweight you are, the more likely you are to have health problems. Weight loss and regular exercise can help improve the harmful effects of being overweight. Studies show if you are overweight or obese, losing 5–10% of your body weight can improve your health.

To read more about how overweight and obesity affect your health, visit

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), *You Know the Health Risk of Being Overweight*
http://www.niddk.nih.gov/health/nutrit/pubs/health.htm

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity, Overweight and Obesity:The Health Consequences
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.htm

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What can be done about this major public health problem?

The Surgeon General recently called for a broad approach to avoid and reduce obesity. He challenged families, schools, work sites, health care providers, communities, and the media to work together to prevent and reduce obesity through

- Communication—by educating, motivating, and empowering decision makers at all levels to create healthier communities.
- Action—by helping Americans balance healthy eating with regular physical activity.
- Research and Evaluation—by improving the general public's understanding of the causes, prevention, and treatment of overweight and obesity.

To read more about what can be done, visit

*The Guide to Community Preventive Services**
http://www.thecommunityguide.org/pubrecs_f.html

CDC, PDF file of Morbidity and Mortality Weekly Report Oct. 26, 20001/Vol 50/No. RR-18, Increasing Physical Activity: A Report on Recommendations of the Task Force on Community Preventive Services**
http://www.cdc.gov/mmwr/pdf/rr/rr5018.pdf

**You will need Acrobat Reader (a free application) to view and print this document.

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity, Overweight and Obesity: What Can You Do?
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_whatcanyoudo.htm

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity: A Vision for the Future
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_vision.htm

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What are the costs associated with overweight and obesity?

- In 2000, the cost of obesity in the United States was more than $117 billion.
- Poor nutrition and physical inactivity account for some 300,000 premature deaths in the United States each year.

To read more about the cost of overweight and obesity, visit

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity: Economic Consequences
http://www.surgeongeneral.gov/topics/obesity/calltoaction/1_3.htm

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What is CDC doing to address the problem of overweight and obesity?

In October 2000, CDC's Division of Nutrition and Physical Activity funded a number of state health departments to help them develop and carry out targeted nutrition and physical activity interventions in an effort to prevent chronic diseases, especially obesity.

CDC, Division of Nutrition and Physical Actvity, CDC's *State-based Nutrition and Physical Activity Program to Prevent Chronic Diseases, Including Obesity*
http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm

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What does CDC recommend to help people lose weight?

- The safest and most effective way to lose weight is to reduce calories and increase physical activity. It is best to consult with your personal physician or health care professional for advice to meet your needs.
- Government research and recommendations can provide the facts based on science so that people can make informed choices about appropriate weight loss. The fact is the majority of people who are attempting weight loss are not using the correct method to achieve or maintain positive results.

For more information about recommendations, visit

USDA *The Food Guide Pyramid*
http://www.nal.usda.gov:8001/py/pmap.htm

The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity: Health Weight Advice for Consumers
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_advice.htm

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"Many people believe that overweight and obesity is a personal responsibility. To some degree they are right, but it is also a community responsibility.When there are no safe, accessible places for children to play or adults to walk, jog, or ride a bike, that is a community responsibility. When school lunchrooms and office cafeterias do not provide healthy and appealing food choices, that is a community responsibility. When new or expectant mothers are not educated about the benefits of breastfeeding, that is a community responsibility. When we do not require daily physical education in our schools, that is also a community responsibility. There is much that we can and should do together."
- David Satcher, The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity,2001

Physical Activity, Nutrition and Obesity

NEW! Obesity is a public health crisis, it will take more than willpower to reverse the trend - *Guest opinion by Mel Kohn, M.D., State Epidemiologist.*

Welcome to the Oregon website for A Healthy Active Oregon. On this site you will find the The Statewide Physical Activity Plan and the The Statewide Public Health Nutrition Plan.

These two companion documents have at their core a focus on developing communities where the healthy choices are the easy choices: where adults and children have easy access to fresh vegetables, fruits, and other healthy foods at school, work, and when eating out; where Oregonians can safely walk and bicycle for work, errands, and recreation. The ultimate goal is for all Oregonians to enjoy improved health and reduced risk of chronic diseases through daily physical activity and healthy eating in communities that support those choices.

These plans are calls to action for all who can have an impact on promoting healthy eating and daily physical activity in order to improve the health of Oregonians. Achieving these changes will require involvement of individuals from many arenas – policymakers, transportation and land use planning, health care, public health, parks and recreation, business sector, voluntary health organizations, schools and universities, employers, insurers, and citizen groups.

A Healthy Active Oregon:

The Statewide Physical Activity Plan

Oregon Coalition for
Promoting Physical Activity

February 2003

www.healthoregon.org/hpcdp/physicalactivityandnutrition/

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Executive Summary

The Statewide Physical Activity Plan and its companion document, the Statewide Public Health Nutrition Plan, are calls to action for all who can have an impact on promoting daily physical activity and healthy eating to improve the health of Oregonians.

Adequate physical activity and healthy eating have long been recognized as essential ingredients for good health. Yet, too many Oregonians lead sedentary lives and have poor eating habits. Inactivity and poor food choices contribute significantly to the development of obesity, high blood pressure, heart disease, cancer, and diabetes, which are leading causes of disease and death among Oregonians. Fully one-third of premature deaths can be attributed to poor eating and physical inactivity. These two risk factors combined are the number-two preventable cause of death in Oregon and the United States. Only tobacco kills more people.

The current epidemic of obesity in the U.S. has hit Oregon particularly hard. At 22%, our state has the highest percentage of adult obesity of any state west of the Rockies. Add to that the 38% of Oregon adults who are overweight and we have the startling total of 60% of Oregon adults not at a healthy weight. Our youth follow closely behind, with 28% of eighth graders and 21% of eleventh graders currently overweight.

The food environment has changed dramatically in the last twenty years, paralleling the increase in overweight and obesity. Advertisements and media messages, "super-sized" portions, and promotional pricing encourage consumption of foods high in calories, sugar, and fat. Abundant fast-food restaurants, vending machines, and convenience stores make the same high-calorie, high-fat, high-sugar foods readily available and inexpensive.

At the same time we are encouraged to eat more, we have many fewer opportunities during the day to use those additional calories. Office jobs require hours of sitting, elevators replace stairs, physical education in schools is being eliminated, TV and computers are used extensively during leisure time, and we rely almost exclusively on autos for travel. Many opportunities for physical activity have been engineered out of our daily lives.

"Physical activity and good nutrition are key factors in reducing heart disease, stroke, cancer, and diabetes – the leading causes of death for Oregonians. We need to unite individuals and groups across the state in actions that remove barriers to daily physical activity and healthy food choices."
-Mel Kohn, MD, MPH, State Epidemiologist for Oregon

Only 39% of Oregon's adults currently meet the physical activity recommendation of 30 minutes most days of the week. About 70% of eighth grade students and 50% of eleventh grade students meet the minimum recommendation for physical activity. Many fewer female students meet the recommendation than males, especially by eleventh grade.

"Many people believe that overweight and obesity is a personal responsibility. To some degree they are right, but it is also a community responsibility. When there are no safe, accessible places for children to play or adults to walk, jog, or ride a bike, that is a community responsibility. When school lunchrooms and office cafeterias do not provide healthy and appealing food choices, that is a community responsibility. When new or expectant mothers are not educated about the benefits of breastfeeding, that is a community responsibility. When we do not require daily physical education in our schools, that is also a community responsibility. There is much that we can and should do together."
-David Satcher, The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001

Interventions to promote physical activity and healthy eating and to reduce disease risks have almost always focused on changing the behavior of individuals. While individuals ultimately make the choices about food and physical activity, the environment in which we live has an enormous impact on how easy those choices really are. Unfortunately, current community conditions present more barriers than opportunities for daily physical activity and healthy eating.

The Statewide Physical Activity Plan and companion Statewide Public Nutrition Plan have at their core a focus on developing communities where the healthy choices are the easy choices; where Oregonians can safely walk and bicycle for work, errands, and recreation; where adults and children have easy access to fresh vegetables, fruits, and other healthy foods at school, work, and when eating out. Achieving these changes will require involvement from a wide variety of participants: local, regional, state, and national policymakers, transportation officials, land use planning professionals, public health, schools, universities, parks and recreation, business, voluntary health organizations, employers, health care providers and insurers, and citizen groups. Working together, Oregonians can achieve the key outcomes of these two plans, described below, through partnerships, collaboration, and investment of resources.

Statewide Physical Activity and Nutrition Key Outcomes:

- Increase physical activity among Oregon youth and adults.
- Increase vegetable and fruit consumption among Oregon youth and adults.
- Increase the percentage of Oregonians who are at a healthy weight.
- Create communities that support and promote daily physical activity, healthy eating, and healthy weight.
- Eliminate health disparities among racial and ethnic communities, medically underserved, low-income, senior, disabled, and rural populations.
- Support a comprehensive, coordinated statewide effort to promote daily physical activity and healthy eating.

A Healthy, Active Oregon:
The Statewide Public Health Nutrition Plan

Nutrition Council of Oregon

February 2003

www.healthoregon.org/hpcdp/physicalactivityandnutrition/

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DENTAL HEALTH PROGRAM

I. Who We Are:

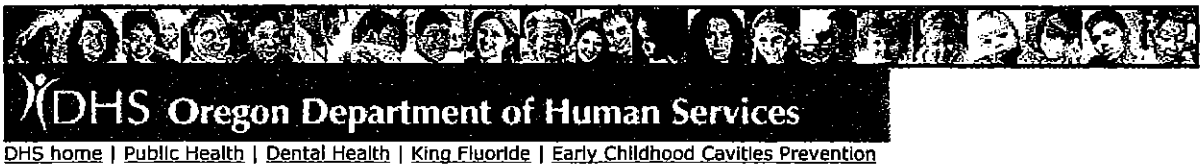
The Dental Health Program seeks to improve the oral health of Oregon's children. We work to decrease the number of children with decayed, filled or missing teeth, increase the number of children with preventative dental sealants in their adult molars and increase the percent of people served by community fluoridated water systems. These goals are consistent with the Healthy People 2010 Oral Health Objectives for the nation.

II. Program Reports and Documents:

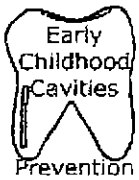
Oregon Oral Health Needs Assessment Executive Summary
1991-93 State Fluoridation map
Early Childhood Cavities Prevention education packet

III. Why We're Here:

We coordinate the state wide school-based King Fluoride Program. We provide technical assistance for dental sealant programs in operation in Clackamas, Marion, Tillamook, Douglas and Hood River counties. Assistance is provided to local health departments, public health programs, Head Start programs and other partners by promoting preventive health activities/programs, providing education, and gathering, interpreting and disseminating current preventive dental health information and resources. We work to maintain and improve the state and local preventative dental health programs and collaborate with other partners to establish and implement new programs.



Dental Health



"It takes a village to grow healthy smiles" Packet

ECCPC Letter to Physicians and Health Care Providers

Table of Contents:

This packet of oral health information is a resource for parents, health care providers, and well-child professionals.